

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049321
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 13123

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
1								
2 <u>21</u>								
3								
4 <u>3</u>								
5 <u>2</u>								
6								
7 <u>1</u>								
8 <u>2</u>								
9								
10								
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12 <u>910-0</u>								
13								
90								

FILED JAN 9 1964		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3909 Enright</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3909 Enright</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Carter</u> Last <u>Carter</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>63</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1892</u>	9. AGE (last birthday) <u>71</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Domestic</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Lake Provident La.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Wallace Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Evans</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Rebecca Victor</u>		Address <u>3909 Enright</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>3.32x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12-20-63</u> to <u>12-31-63</u> and last saw her alive on <u>12-27-63</u> Death occurred at <u>9:15</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. E. Smith, M.D.</u> (Degree & title)		22b. ADDRESS <u>2715 Union St. Kansas</u>		22c. DATE SIGNED <u>12-31-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-6-64</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	
23d. LOCATION (City, town, or county) <u>Berkeley</u>		23e. STATE <u>Mo.</u>		24. FUNERAL DIRECTOR <u>Atkins Bros. 3644 Finney Ave.</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 3 1964</u>		26. REGISTRAR'S SIGNATURE <u>Road Smith, M.D.</u>			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.